Investigation Findings Report

License #	Investigation ID	Date Investigation Received:	09/28/2011
785-01-001	2	**Date Investigation Closed:**	

Investigated by: Ed Gonzalez

Investigation Description:
OL Specialist received complaint from Ms. May regarding a incidents that occurred regarding her sister. Incident of 9/17/11 related to fall that resulted in a arm fracture. Incident of 9/25/11 related to peer hitting sister in the fractured arm that was recently surgically repaired. OL Specialist indicated that he would investigate with Human Rights Advocate, Stewart Prost.

Inspection Date	Inspection Summary Description
10/06/2011	A unannoucned complaint investigation was initiated on 10/6/11. OL Specialist and Human Rights Advocated participated in a joint investigation with Virginia Beach APS. Staff interviewed and records reviewed. Please submit acceptable corrective action by December 23, 2011 to: Ed.Gonzalez@DBHDS.Virginia.gov

Regulations Cited

150.4	Human rights law and regulations
580.B	Structured program of care
590.A	Staffing plan to include type & role of employees
590.D	Staffing to meet specialized needs
660.C.2	Relevant psychological, behavioral, medical, rehabilitation and nursing needs

Investigation Findings

A joint investigation was initiated with the Office of Licensing (OL), Office of Human Rights (OHR) and Virginia Beach Adult Protective Services (VB APS). All offices worked collaboratively in gathing as much information to make a determination of findings.

First incident involved resident at the Pleasente Vue residence sustaining a serious fracture to the right arm. Guardian reported to VB APS and to OL Specialist that "client sustained an injury at the residential home. Caller is questioning the cause of the injury." Caller also reported ongoing physical abuse of the client by another peer in the home.

On 9/17/11, Guardian/sister received a call from the owner of the group home. According to the owner, an aide in the group home heard a nosie, went to investigate and saw the client getting off the floor. The caregiver assisted the client with taking a shower and observed swelling of arm. The client was taken to Sentara Bayside ER, diagnosed with a fractured arm, treated, and sent home.

The second incident occurred on 9/24/11 and it involved another resident hitting I1 on her recently surgically repaired arm. The guardian observed resident hit the caller's sister, very hard, on the arm that had been broken. Guardian indicated that resident has a history of hitting or scratching other residents.

OL Specialist, Ed Gonzalez and Human Rights Advocate, Stewart Prost, completed an unannounced complaint investigation on October 6, 2011. I1's documentation was reviewed. Requested and received progressive notes and medical information regarding incident. Owners, Lawrence and Sandy Baptiste, were interviewed. Guardian/Sister was interviewed. Another sister was called and overnight staff was called a couple of times.

Investigation Findings Report

OL Specialist spoke to Guardian/Sister on several occassions regarding her sister's treatment at Pleasante Vue. Concerns raised included: inadequate care, medications changes without notification of the guardian, found bruises, money management issues and poor communication.

OL Specialist was unable to substantiate abuse/neglect regarding fall that attributed to fracture of the arm. OL Specialist was able to substantiate that abuse/neglect did occur with regards to this individual being hit by another peer. The provider failed to keep the individual safe from harm and this incident resulted in a FOUNDED case of abuse and neglect. EG

FINDINGS:

OL Specialist spoke with APS worker on 11/9/11. APS worker informed OL Specialist that due to the individual being removed from the residence that the need to continue oversight would not be warranted. She did indicated that after interviewing one of the owners that the residence had failed to provide additional staff to monitor resident who hit I1 on the arm. Evidently, second staff scheduled for that day had called out sick. APS to forward findings to OL Specialist.

The Human Rights advocate submitted a request to OL to cite the provider for failure to report incidents to the Office of Human Rights and to submit report finding in a timely matter.

Based on information gathered, first incident was NOT FOUNDED for abuse and neglect. OL Specialist could not determine, based on interviews and information gathered that the provider acted neglectful in the resident sustaining a broken arm.

Based on the information gathered in the second incident, the guardian witnessed a resident hitting I1 on the arm that had been surgically repaired. OL Specialist determined that this is a FOUNDED case of abuse/neglect. The Provider failed to have appropriate staffing in the home to deal with the population served and the provider did not have a valid updated behavioral plan to address behaviors of the resident who had hit others in the home. Corrective Action will be submitted. Provider has been placed on a Provisional License and will not be able to admit any further residents during this licensing period. EG